Gastroenterology Referral Form

amerita specialty infusion services

EVENTUS Rx an amerita company

Fax completed form to: _____

PATIENT INFORMATION

Patient Name:	Date of Birth:	Referral Date:
Address:	City/State/Zip:	
Home Phone:	Cell Phone:	Work Phone:
Secondary Contact:	Height: Weight:	☐ Male ☐ Female
Patient Diagnosis & ICD-10:		
Allergies:		

PROVIDER INFORMATION

Physician Name:	Lic.#:	DEA #:
Practice Name:		NPI#:
Address:		City/State/Zip:
Office Contact:	Phone:	Fax:
Supervisory Physician (if applicable):		

PLEASE ATTACH

- ☐ Patient demographics & front/back copy of all insurance cards (prescription & medical)
- ☐ Recent office visit notes, history & physical, lab & pertinent procedure results
- ☐ Current medication list & list of prior medications tried and failed (with dates)
- ☐ Line access documentation/verification if applicable
- ☐ Vaccine status (any vaccination) and documentation of any recent vaccinations
- ☐ TB lab results within last 12 months
- ☐ HBV lab results within last 12 months *(Infliximabs only)*
- ☐ Liver enzymes lab results *(Skyrizi only)*
- ☐ Bilirubin levels *(Skyrizi only)*
- ☐ Letter of medical necessity if drug dosing or indication is outside of FDA guidelines

NURSING & LAB ORDERS

Nurse Orders: Nurse to provide assessment, teaching, lab draws, medication administration and vascular access device insertion.
Flush Orders: *NaCl 0.9%* - 5-10mL flush pre and post infusion and as needed *Heparin* - ☐ 10units/mL ***---OR---*** ☐ 100units/mL - 3-5mL flush after post-infusion NS flush if indicated to maintain line

Lab Orders: **Lab Date & Frequency:**

PRESCRIPTION ORDERS

Anaphylaxis Kit: (Check all that apply)
☐ Epinephrine 0.3mg IM as needed ☐ Solu-cortef 250mg-500mg IV as needed ☐ Solu-Medrol 60mg - 125mg IV as needed
☐ Diphenhydramine _____ mg IV as needed ☐ NS Hydration 500 ml IV over 30 minutes as needed ☐ Other

Pre-Medications: (Check all that apply)
☐ Acetaminophen _____mg PO _____minutes prior to infusion ☐ Solu-Medrol _____mg IV ____minutes prior to infusion
☐ Diphenhydramine _____mg ☐ PO ***---OR---*** ☐ IV _____minutes prior to infusion ☐ Other

Supply Orders: All supplies for vascular access line care, drug administration kit(s), pump, and IV pole will be provided as necessary

PRODUCT	PRESCRIPTION INFORMATION			REFILLS
Is this a first dose? ☐ Yes ☐ No If No, when was last dose given?_____ When is patient due for next dose?_____				
☐ CIMZIA®	☐ 200x2 Prefilled Syringe ☐ 200x2 LYO Powder	☐ Starter Kit: Inject 400mg subcutaneously at weeks 0, 2 and 4 ☐ Inject 400mg subcutaneously once every 4 weeks	1 Kit 4 week supply	NONE _____
☐ ENTYVIO	☐ **Induction**: 300mg IV infusion over 30 minutes at week 0, 2, and 6			NONE
	☐ **Maintenance**: 300mg IV infusion over 30 minutes every _____ weeks			_____
☐ HUMIRA® Citrate Free	☐ Crohn's/UC Starter Package (8mg - 80mg Pens) ☐ 40mg Pen ☐ 40mg PFS	Inject 160mg given as ☐ Two 80mg SubQ Day 1 ***--OR--*** ☐ One 80mg SubQ Days 1 & 2, then Week 2 inject 80 mg subcutaneously on Day 15 ☐ Week 4+: Inject 40mg subcutaneously every other week	Loading Dose 4 week supply	NONE _____
☐ INFLIXIMAB ☐ Avsola ☐ Inflectra ☐ Remicade ☐ Renflexis	☐ **Induction**: _____mg/kg or _____mg IV infusion over at least 2 hours at weeks 0, 2, and 6			NONE
	☐ **Maintenance**: _____mg/kg _____ mgIV infusion over at least 2 hours every _____ weeks *(Note: Round to nearest 100mg for Medicaid patients)* If Remicade infusion tolerated, adjust infusion time according to manufacturer package insert.			_____
☐ SKYRIZI	☐ **Induction**: 600mg IV infusion over one hour at week 0, 4, and 8			NONE
	☐ **Maintenance**: 360mg SC injection at Week 12, and every 8 weeks thereafter			_____
☐ STELARA	**Induction (Adult Dosing -Based on body weight of patient at time of dosing):** ☐ For patients 55kg or less administer 260mg IV infusion over at least 1 hour x 1 dose ☐ For patients more than 55kg to 85kg administer 390mg IV infusion over at least 1 hour x 1 dose ☐ For patients more than 85kg administer 520mg IV infusion over at least 1 hour x 1 dose			NONE
	☐ **Maintenance**: 90mg SubQ injection _____ weeks after induction and every _____ weeks thereafter			_____
☐ OTHER				NONE

By signing this form and utilizing our services, you are authorizing EventusRx to serve as your prior authorization designated agent in dealing with medical and prescription insurance companies.

Prescriber's Signature **Print Name** **Date**
Dispense Permitted

Prescriber's Signature **Print Name** **Date**
Substitution Permitted

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ACHC ACCREDITED